



COMMONWEALTH of VIRGINIA

Dianne L. Reynolds-Cane, M.D.
Director

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September 14, 2012

Scott C. Schuett, A.L.F.A.

Certified Article Number

7196 9008 9111 0156 1294

SENDERS RECORD

RE: Notice of Formal Hearing
License No.: 1706-0000506
Preceptor Registration No.: 1707-000060
Case No.: 14S346 & 143951

Dear Mr. Schuett:

On September 13, 2012, the Virginia Board of Long-Term Care Administrators ("Board") received investigative information indicating that you may have violated certain sections of the Code of Virginia (1950), as amended. Based on the evidence considered, having determined that your practice poses a substantial danger to the public health and safety, the Board voted to summarily suspend your license to practice assisted living facility administration in the Commonwealth of Virginia pending a hearing. Effective immediately, it shall be unlawful for you to practice as an assisted living facility administrator or hold yourself out as an assisted living facility administrator in the Commonwealth of Virginia.

Enclosed is a Notice of Hearing and Statement of Particulars. The hearing will be held before the Virginia Board of Long-Term Care Administrators on **October 30, 2012**, at 9:00 a.m. at the offices of the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

You have the following rights, among others: to be represented by legal counsel, to have witnesses subpoenaed on your behalf, to present documentary evidence and to cross-examine adverse witnesses. Should you wish to subpoena witnesses, requests for subpoenas must be made in writing in accordance with the enclosed Instructions for Requesting Subpoenas.

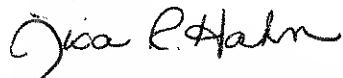
You have the right to information on which the Board will rely in making its decision. Prior to the hearing, it is the Board's intention to distribute the enclosed documents to the members of the Board who will conduct the hearing. **These documents are enclosed only with the original notice sent by certified mail, which you may be required to claim at the post office.** If you have any objections to the materials, please notify the Board of Long-Term Care Administrators in

writing, at 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, before **October 17, 2012**. A copy of any written objections must also be sent to David W. Kazzie, Adjudication Specialist, Administrative Proceedings Division, at the same address and to Corie Tillman Wolf, Assistant Attorney General, 900 East Main Street, Richmond, Virginia 23219. If you do not object to this proposed distribution before **October 17, 2012**, the Board will assume that you have no objection to the Board members' prior review of the documents. Failure to object to the distribution prior to the hearing will not affect your right to contest any information contained in these documents at the hearing.

Further, to facilitate this hearing, the Board requests that you provide to David W. Kazzie, Adjudication Specialist, Administrative Proceedings Division, Department of Health Professions, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, **fifteen copies of any documents you intend to introduce into evidence at least ten (10) business days before the hearing.**

Please advise us whether you plan to be present for the hearing no later than October 17, 2012.

Sincerely,



Lisa R. Hahn, Executive Director
Board of Long-Term Care Administrators

Enclosures

cc: Members of the Board of Long-Term Care Administrators
Anne G. Joseph, Deputy Director, Administrative Proceedings Division
Corie Tillman Wolf, Assistant Attorney General
David W. Kazzie, Adjudication Specialist
Kelly D. Ashley, Investigator, Division of Enforcement (Case No. 143951 & I45346)

BEFORE THE BOARD OF LONG-TERM CARE ADMINISTRATORS

IN RE: **SCOTT C. SCHUETT, A.L.F.A.**

License No.: 1706-000506

Preceptor Registration No.: 1707-000060

Case No.: 145346 & 143951

ORDER OF SUMMARY SUSPENSION

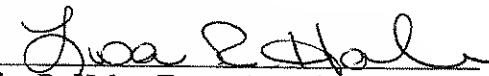
Pursuant to § 54.1-2408.1 of the Code of Virginia (1950), as amended (“Code”), a quorum of the Board of Long-Term Care Administrators (“Board”) met by telephone conference call on September 13, 2012, after a good faith effort to convene a regular meeting of the Board had failed. The purpose of the meeting was to receive and act upon certain information indicating that Scott C. Schuett, A.L.F.A., may have violated certain laws and regulations relating to the practice of assisted living facility administration in the Commonwealth of Virginia, as more fully set forth in the attached “NOTICE OF HEARING and STATEMENT OF PARTICULARS,” which is attached hereto and incorporated by reference herein.

WHEREUPON, pursuant to its authority under § 54.1-2408.1(A) of the Code, the Board concludes that a substantial danger to public health or safety warrants this action and ORDERS that the licenses of Scott C. Schuett, A.L.F.A., License No. 1706-000506 to practice as an assisted living facility administrator and Registration No. 1707-000060 to practice as an assisted living facility administrator preceptor in the Commonwealth of Virginia are hereby SUSPENDED. It is further ORDERED that a hearing be convened forthwith to receive and act upon evidence in this case and that the Executive Director of the Board shall be authorized to execute this Order and all other documents, notices and orders on behalf of the Board necessary to bring this matter to a hearing.

Upon entry of this Order, the licenses of Scott C. Schuett to practice as an assisted living facility administrator and to practice as a preceptor in the Commonwealth of Virginia will be recorded as suspended and no longer current.

Pursuant to § 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection or copying on request.

FOR THE BOARD


Lisa R. Hahn, Executive Director
Virginia Board of Long-Term Care Administrators

Entered: September 14, 2012

VIRGINIA:

BEFORE THE BOARD OF LONG-TERM CARE ADMINISTRATORS

IN RE: SCOTT C. SCHUETT, A.L.F.A.

License No.: 1706-0000506

Preceptor Registration No.: 1707-000060

Case No.: 145346 & 143951

NOTICE OF HEARING

Pursuant to §§ 2.2-4020, 2.2-4024(F), and 54.1-2400(11) of the Code of Virginia (1950), as amended (“Code”), Scott C. Schuett, A.L.F.A., who, prior to their summary suspension by the Board of Long-Term Care Administrators on September 13, 2012, held License No. 1706-000506 to practice as an assisted living facility administrator and Registration No. 1707-000060 to practice as an assisted living facility administrator preceptor, is hereby given notice that a formal administrative hearing will be held in the presence of a panel of the Board of Long-Term Care Administrators. The hearing will be held on October 30, 2012, at 9:00 a.m., at the offices of the Department of Health Professions, Board of Long-Term Care Administrators, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia 23233, at which time Mr. Schuett will be afforded the opportunity to be heard in person or by counsel.

At the hearing, Mr. Schuett has the following rights, among others: the right to representation by counsel; the right to have witnesses subpoenaed and to present witnesses on his behalf; the right to present documentary evidence; and the right to cross-examine adverse witnesses. If Mr. Schuett desires any witnesses to appear on his behalf, he must notify the Director of Administrative Proceedings, Department of Health Professions, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in accordance with the Instructions for Requesting Subpoenas.

The purpose of the hearing is to inquire into evidence that Mr. Schuett may have violated certain laws and regulations governing assisted living facility administration practice in Virginia, as more fully set forth in the Statement of Particulars below.

STATEMENT OF PARTICULARS

The Board of Long-Term Care Administrators ("Board") alleges that Scott C. Schuett, A.L.F.A., may have violated 18 VAC 95-30-210(1), (2), and (4) of the Regulations Governing Assisted Living Facility Administrators in that:

1. During the course of his employment as owner/administrator of Madison Retirement Center, Williamsburg, Virginia:

a. On or about May 8-9, 2012, Mr. Schuett failed to ensure that a diabetic resident who was experiencing high glucose readings received proper supervision, care, and attention, by failing to notify the resident's primary care physician immediately, and next of kin, legal representative, contact person, case manager, and social services agency within 24 hours after the resident fell and after the resident refused transport to the hospital and document any such notification in the resident's record, in violation of 22 VAC 40-72-450(G) and 22 VAC 40-72-460(F) of the Standards for Licensed Assisted Living Facilities ("Standards").

b. On or about May 9, 2012, Mr. Schuett failed to notify the Department of Social Services in a timely manner of the death of the diabetic resident referenced in Allegation #1(a), who was transported to the hospital on May 9, 2012, after staff discovered the resident unresponsive, in violation of 22 VAC 40-72-100(A) of the Standards.

c. On or about May 17, 2012, Mr. Schuett failed to ensure that resident call bells were operational in at least four rooms, in violation of 22 VAC 40-72-910(B) of the Standards.

d. In or about May 2012, Mr. Schuett failed to ensure that a resident had a complete Uniform Assessment Instrument and Individualized Service Plan on file in that the resident's record did not

reflect his substance abuse history, his history of unstable insulin-dependent diabetes, or his need for assistance with grooming and bathing, in violation of 22 VAC 40-72-440 of the Standards.

e. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that residents' medications were administered in accordance with doctors' orders and in a manner consistent with the standards of practice outlined in the current registered medication aide curriculum approved by the Virginia Board of Nursing, in violation of 22 VAC 40-72-640 and 22 VAC 40-72-670 of the Standards.

f. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that the facility had a sufficient supply of food on hand for the residents, and he failed to ensure that residents were provided three well-balanced meals daily that conformed to physicians' orders pertaining to special dietary needs, where applicable, in violation of 22 VAC 40-72-610 and 22 VAC 40-72-620(E) and (F) of the Standards.

g. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that residents' medication administration records were properly maintained, in violation of 22 VAC 40-72-670(H) of the Standards.

h. On multiple occasions in 2012, Mr. Schuett failed to ensure that the facility had enough staff on hand to properly care for and supervise residents, in violation of 22 VAC 40-72-320(A) of the Standards.

i. On multiple occasions in 2012, Mr. Schuett failed to ensure that significant changes in residents' conditions were reported to the residents' physicians, including significant weight loss in approximately 9 residents, in violation of 22 VAC 40-72-450(E) and 22 VAC 40-72-580(G) of the Standards.

j. On multiple occasions in 2011 and 2012, Mr. Schuett failed to properly maintain the facility's building and physical plant in good repair, clean, free of foul odors and free of pest infestation, in violation of 22 VAC 40-72-850 of the Standards.

k. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that all residents had updated tuberculosis screening assessments on file with the facility, in violation of 22 VAC 40-72-350(C)(1) of the Standards.

l. On or about March 12, 2012, Mr. Schuett failed to appoint an interim Administrator to perform the duties of the Administrator in the absence of the facility Administrator while she was out on medical leave and failed to notify the Board and the regional licensing Office of the Department of Social Services that the facility was operating without a licensed Assisted Living Facility Administrator, in violation of § 63.2-1803(B) of the Code of Virginia (1950), as amended.

2. During the course of his employment as owner/administrator of Ashwood Assisted Living Facility, Hampton, Virginia:

a. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that the facility had a sufficient supply of food on hand for the residents, and he failed to ensure that residents were provided three well-balanced meals daily that conformed to physicians' orders pertaining to special dietary needs, where applicable, in violation of 22 VAC 40-72-610 and 22 VAC 40-72-620 (E) and (F) of the Standards.

b. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that the facility had enough staff on hand to properly care for and supervise residents, in violation of 22 VAC 40-72-320(A) and 22 VAC 40-72-580(D) of the Standards.

c. On multiple occasions in 2011 and 2012, Mr. Schuett failed to obtain sexual offender registry information for new facility residents, in violation of 22 VAC 40-72-367 of the Standards.

d. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that PRN medications that had been prescribed to residents were available on-site, in violation of 22 VAC 40-72-670(K) of the Standards.

e. On multiple occasions in 2011 and 2012, Mr. Schuett failed to maintain the building in good repair, clean, free of foul odors, and free of pest infestation, in violation of 22 VAC 40-72-850 of the Standards

f. On multiple occasions in 2011 and 2012, Mr. Schuett failed to obtain mental health screenings and complete physical examinations of prospective residents prior to admission to the facility, in violation of 22 VAC 40-72-350 and 22 VAC 40-72-360 of the Standards.

g. On multiple occasions in 2011 and 2012, Mr. Schuett failed to update residents' mental health reports and individualized service plans in a timely fashion, in violation of 22 VAC 40-72-440 and 22 VAC 40-72-500(D) of the Standards.

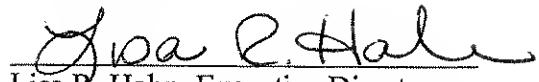
h. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that the facility had a sufficient backup supply of emergency drinking water on hand, in violation of 22 VAC 40-72-960(G) of the Standards.

i. In or about January 2012, Mr. Schuett failed to ensure the preparation of staff/resident assignment sheets, records of activities of daily living, or 24-hour report sheets, as well as menus and activity schedules in violation of 22 VAC 40-72-620(B) and 22 VAC 40-72-520(G) of the Standards.

j. On multiple occasions in 2011, Mr. Schuett failed to ensure that all resident medications were available and being administered in accordance with physicians' orders and in accordance with the standards of practice outlined in the current registered medication aide curriculum approved by the Virginia Board of Nursing, in violation of 22 VAC 40-72-640 and 22 VAC 40-72-670 of the Standards.

k. On multiple occasions in 2011 and 2012, Mr. Schuett failed to ensure that medication administration records were being maintained properly, in violation of 22 VAC 40-72-670(H) of the Standards.

FOR THE BOARD


Lisa R. Hahn, Executive Director
Board of Long-Term Care Administrators

ENTERED: September 14, 202